

Greg Isolani – SUBMISSIONS AND APPEARANCES

Senate Committees –

September 2003 – *Aspects of the Veterans' Entitlement Act 1986 and the Military Compensation Scheme.*

December 2003 – *Administrative review of Veteran's and Military Compensation and income Support.*

March 2004 - *Military Compensation Bill 2003 and the Consequential and Transitional Provisions Bill 2003.*

Commonwealth Government and Department of Defence Inquiries

March 1997 – *Inquiry into the Military Compensation Arrangements for the Australian Defence Force*

June 1998 – *Report into the Policies and Practices to deal with Sexual Harassment and Sexual Offences*

March 1999 – *The Review of the Military Compensation Scheme.*

February 2001 – *Inquiry into the Provisions of the Administrative Review Tribunal Bill 2000 and the Consequential and Transitional Bill 2000*

March 2001 – July 2004 – *DVA National Office - Ex-Service Organisation - Working Group Member.*

February 2002 – *The Clarke Review – Anomalies with Eligibility Including Qualifying Service Provisions under the Veterans' Entitlement Act 1986*

March 2005 – *Comcare Draft Permanent Impairment Guide*



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***RESPONSE TO "GUIDE TO THE ASSESSMENT OF THE
DEGREE OF PERMANENT IMPAIRMENT – 2nd EDITION"-
(The Draft Guide)***

1. INTRODUCTION

- 1.1 On behalf of the Armed Forces Federation of Australia (ArFFA), we welcome the attempt by Comcare to produce a second edition of the Guide due to the number of applications to the Federal Administrative Appeals Tribunal (AAT) and the Federal court regarding the way in which the Guide is used to assess permanent impairment.
- 1.2 The extensive and ongoing Federal Court criticism of the ambiguities of the Guide and how, on occasion, Comcare has attempted to perpetuate such ambiguities has made the need for a new edition of the Guide a high priority.
- 1.3 Notwithstanding the assertion by Comcare that there has been "extensive consultation" with professional associations and legal representatives we have been advised by the *RSL (Victorian State Branch)* together with the *Australian Peacekeepers Peacemakers and Veterans' Association, Injured Service Persons' Association, Armed Forces Federation of Australia, and Regular Defence Force Welfare Association Vietnam Veterans' Federation (NSW Branch)* for whom we act and advise their members, that there was **no consultation with their organisation regarding a revision of the Guide.**

- 1.4 We note that the Ex Service Organisations (ESO's) are accepted widely as playing a crucial role to help Veterans' prepare their compensation and appeal claims, representation to the Veterans' Review Board and have been actively funded and trained by the Department of Veterans' Affairs. Such training and information is via the claims assistance and grants scheme and building excellence in support and training programs (IIP and BEST). It is therefore disappointing that Comcare would not have included the relevant Ex Service Organisations for comment regarding the draft Guide prior to or during the course of the preparation of the draft rather than initially posting a copy to the ESO's and requesting a response to such a complex document with far reaching consequences within 8 days.
- 1.5 The opportunity and forum for Comcare to consult with the ESO's has been facilitated by the inception of the *Department of Veterans' Affairs National Office – Ex Service Organisations Working Group* (DVA-WG) who sat with representatives from Military Compensation and Rehabilitation Scheme and other departmental representatives with respect to the new *Military Rehabilitation and Compensation Act 2004*.
- 1.6 Therefore, there seems to be a either an unwillingness or inability by the Department of Employment and Workplace Relations (DEWR) who are responsible for Comcare, to consult with Department of Veteran's Affairs (DVA) or at least request whether any ESO's should be a part of the Comcare committee whilst the draft Guide was prepared. This is a significant oversight as DVA's clients are current and former members of the Australian Defence Force (ADF) who represent the greatest number of claimants whose entitlements will be affected by the proposed draft Guide.
- 1.7 We highlight at the outset and further in our response that if the purpose of the draft Guide was to not only provide, "an accurate up to date objective and medically accepted system measuring all impairments" but, in accordance with the beneficial nature of the SRC legislation, to reduce the current ambiguities under the existing Guide and to compensate people for permanent impairment, then it has failed.

1.8 This is abundantly clear when reference is made to the comparisons in the “Attachment A and B “whereby those conditions and injuries that could be assessed at the minimum of 10% under the current Guide would, on the whole not reach the 10% Whole Person Impairment. Given that the *Safety Rehabilitation and Compensation Act* is “beneficial legislation” it is reasonable that the draft Guide would therefore reduce the ambiguities and compensate more people, rather than less people by not redrafting the Guide in such a narrow and prescriptive way.

2. AUSTRALIAN DEFENCE FORCE (ADF) AND THE DRAFT GUIDE - RETROSPECTIVE AND MUSCULO-SKELETAL INJURIES.

2.1 The nature of ADF injuries arise generally due to the hazardous and dangerous nature of service undertaken by ADF personnel that differs significantly from employment undertaken by Commonwealth civilian employees. This is outlined in the pie graph from *Department of Veterans' Affairs National Office – Ex Service Organisations Working Group (DVA-WG)* provided by Defence Personnel regarding the nature of injuries. The graph highlighted that the significant proportion of ADF injuries, that is 68% are musculo-skeletal i.e. Injuries to the back 28%, knee 19%, lower limb (excluding knee), upper limb 8%. These would seem to be the “cluster” of injuries that the draft Guide will deny a lump sum benefit by assessing the impairment at less than 10% whole person.

2.2 The majority of ADF injuries using the pie graph above i.e. 68% are those injuries to ADF members arising on or before July 2004 that may or may not have resulted in a claim for compensation being lodged pursuant to the *Safety Rehabilitation and Compensation Act*. If a claim for that injury has been lodged then there may not have been a request by the person to claim for a lump sum for permanent impairment. The reluctance by current and former members of the ADF to lodge claims or if a claim has been lodged to request an assessment for permanent impairment are well known. The reasons for late lodgement of claims from the time of the injury is, although at times misguided, accepted by DVA notwithstanding the ongoing campaign by DVA to reduce the latency of claim lodgement by ADF members contemporary to the event.

- 2.3 The reasons include that the serving member not wanting to jeopardise their service by making claims for an injury as it may, in effect assert that their condition may now cause a permanent restriction to perform their service. In other cases, the individual may simply be unaware that they can lodge claims and believe that they have to be discharged before doing so. In other cases the claim for permanent impairment may have to be deferred until further treatment is undertaken i.e. surgery.
- 2.4 Given the uniqueness of the injured ADF member, we urge that firstly the inception of a second edition Guide should not apply at all to current or former members of the ADF. Alternatively the Guide should only apply to injuries that are the subject to a primary claim on and from the inception of the Guide, assuming that date to be 1 January 2006. This will ensure, for example those injuries that have been claimed before that date and may not have stabilised i.e. that require surgery or a reasonable period for stabilisation before the impairment can be assessed as “permanent” will be the subject of the current Guide and not the draft Guide that is likely to deny the ADF member a lump sum.
- 2.5 A further alternative is that an assessment can be made under the existing Guide or the new guide and that whichever Guide provides for a higher assessment will be accepted. This will be consistent with the *Safety Rehabilitation and Compensation Act* as being “beneficial legislation” and to acknowledge the unique and hazardous nature of ADF service.
- 2.6 Given that the proposed draft Guide will have such an impact on ADF members who are predominantly affected by musculo-skeletal injuries and that the “trial run” in Attachments A and B reveals that 57% would have a lower payment or no entitlement if their assessments were made under the Draft Guide, it is unacceptable and an affront for the injured ADF member to allow the Draft Guide to discriminate between their injuries depending on when they happen to have lodged a claim.

INTRODUCTION TO SECOND EDITION OF THE GUIDE

3. Application of this Guide (xv)

3.1 As noted in paragraphs 2.1 to 2.5, lump sum claims will be treated differently if not denied to the ADF member if the draft Guide is implemented after 1 January 2006.

3.2 We submit at the outset the attempt by the Commonwealth to in effect “extinguish a beneficial entitlement retrospectively has previously been deemed “unconstitutional” due to the unjust acquisition of property pursuant to the Commonwealth Constitution. The decision of Georgiadis whereby s.44 of the *Safety Rehabilitation and Compensation Act* attempted to deny a Commonwealth employee’s right to sue if they had not done so by 1 December 1988 was deemed an unjust acquisition of property and therefore invalid

Accordingly, the attempt by the Commonwealth to again extinguish an entitlement by the inception date of the draft Guide to claims for injuries that arise before the draft Guide is implemented may again be a constitutional breach.

3.3 We note that the Draft Guide makes no attempt to assist the Commonwealth to determine the vexed issue of permanent impairment for injuries that arise prior to December 1988 that may manifest or significantly worsen after December 1988.

We believe it would be extremely useful for the draft Guide to make reference to define terms such as “significant worsening”, “pathophysiology” and “qualitative and quantitative change of conditions”. This will be consistent with the Federal Court decisions to determine if a condition, that may not have been capable of assessment or a lump sum entitlement prior to December 1988 (ie under the 1971 Act) may be assessed under the *Safety Rehabilitation and Compensation Act* in accordance with the current guide (whatever draft that may be) to determine if there has been a significant worsening.

4. Increasing Degree of Whole Person Impairment (xvii)

- 4.1 Under the current Guide where, for example a person sustains a secondary condition that was not the subject of final impairment assessment at the time the primary condition was assessed and a lump sum paid, it will not result in a further lump sum unless the overall condition has worsened by 10% whole person.
- 4.2 It is submitted that if the secondary condition equals 10% Whole Person Impairment Comcare should accept and pay a lump sum payment for the 10% Impairment for that secondary condition.
- 4.3 This will reduce the anomaly where a person may have suffered a physical condition, for example fractures to the face that results in a whole person impairment of 10% using Table 4.2 of the current Guide and receives a lump sum payment pursuant to s24 and s27 of the SRCA. Thereafter they experience a psychiatric condition i.e. Post Traumatic Stress Disorder (PTSD) that may not be diagnosed until some years after that event and the subject of a new claim.
- 4.4 If the PTSD condition is assessed at 10% whole person using Table 5 of the current Guide is combined pursuant to Table 14 it is only a 19% Whole Person Impairment. Therefore the overall assessment has not “increased” by 10% whole person and no lump sum is payable.

We submit this is a gross anomaly that has arisen, in particular from the Federal Court and that the draft Guide can rectify rather than perpetuate the anomaly by allowing for an increase in the impairment for secondary condition.

5. Principles of Assessment (xix)

5.1 Aggravation

We are uncertain why there should be an attempt to, in effect, “discount” an aggravation of an underlying pre existing condition. In particular the Courts

have been clear that the aggravation of pre existing conditions, for example degenerative conditions, requires that the assessment of the total condition including the aggravation of any such pre existing condition be made pursuant to the relevant Table.

5.2 Combined Values Table- CVT

The unintended consequence of the combined values table under the current Guide is to deny an equitable assessment of catastrophic injuries and for ADF members a substantial increase of a lump sum payment through a “Severe Injury Adjustment “of 80% whole person.

For example, a person who suffers multiple physical injuries and a secondary psychiatric condition that are assessed at 60% whole person impairment requires an additional impairment of 50% whole person impairment when using the CVT to achieve an assessment of 80% whole person.

5.3 The manner in which the CVT’s are designed and perpetuated under the draft Guide to reduce combined impairments will continue to seriously disadvantage and deny the ADF member with multiple injuries from obtaining a combined whole person impairment at 80% and therefore the Severe Injury Adjustment.

6. Exceptions to use of this Guide (xxi)

6.1 We note that notwithstanding that the American Medical Association’s “*Guide to the Evaluation of Permanent Impairment – Current Addition*” (AMA Guide) is largely the basis upon which the draft Guide is modelled, the American guide cannot be used for a permanent impairment regarding “Mental and behavioural impairment (psychiatric conditions)” together with conditions of the visual system, hearing impairment or chronic pain conditions”.

6.2 We submit that the AMA Guide may be a useful tool and totally appropriate for medical practitioners, in particular psychiatrists to consider a cluster of symptoms that may have manifested due to a particular incident or an event

many years before to determine whether there is now a diagnosable psychiatric condition that can be assessed for permanent impairment.

- 6.3 This is consistent with the Federal Court's approach that psychiatric conditions can only be accepted if they are a "diagnosable" psychiatric condition. Therefore the AMA Guide is a useful tool for not only diagnosing such conditions but to assess whether they have resulted in a permanent impairment.

SPECIFIC REFERENCE AND CONCERNS REGARDING THE "GUIDE TO THE ASSESSMENT OF THE DEGREE OF PERMANENT IMPAIRMENT – 2nd ED"

(a) Disfigurement and Skin Disorders (page 25)

The assessment as to what constitutes facial disfigurement and in particular whether the minimum 10% Impairment can be reached in particular using Table 4.2 and 4.3 is too dramatic.

For example, is it reasonable to conclude that a scar or skin graft that "significantly altered the appearance of the face" should not attract a minimum 10% Whole Person Impairment purely because there is a "less than 5%" of facial area that it covers? If, for example the 4.5% of facial area is between the eyes or at the tip of the nose that should be considered to "significantly alter the appearance of the face". However there would be no entitlement to compensation under the draft Guide.

The assessment of "bodily disfigurement" whereby again percentages of between 11 and 12% of scars or skin grafts that occupy the body of a surface are deemed not to constitute an impairment that attracts a minimum 10% is inequitable for the person who suffers from that condition. For example, having a scar of 11% surface area across the throat should equal a 10% whole person impairment.

(b) Psychiatric Condition (Page 29)

The continual reliance upon and reference to “Activities of Daily living” regarding the nature and extent of a person’s psychiatric condition is to onerous on an Applicant.

For example, a person may have a significant psychiatric condition but is still able to “stand, move, feed have control of their bladder and bowel and undertake self care”. That is, undertake Activities of Daily Living without supervision and direction.

Therefore the requirement that a person’s “Activities of Daily Living” require some supervision and direction or for example, they cannot be assessed at 10 whole person impairment remains inequitable.

Again we note that the inability to rely upon the AMA Guide (5th Edition) as referred to in paragraph 6.1 and 6.2 with respect to a psychiatric condition is restrictive and not in accordance with the overall make up of the draft guide that is loosely based upon the AMA Guide.

(c) Ear Nose and Throat Disorders (Page 43)

We submit that the alteration of Tinnitus that only provides a maximum 5% whole person impairment if it causes “extreme distress, interferes with concentration and is not assisted by a low level noise generator” significantly impacts upon and minimises the effect of this condition upon former members of the ADF who suffer from this condition.

We submit that Tinnitus if continuous and irrespective of it being considered “a nuisance value” should be accepted at a minimum 5% whole person and when the condition is “severe” that it should be given a higher assessment ie 10% or greater.

With respect to “olfaction and taste” we submit that a complete loss of a person’s ability to detect odour or taste should rate higher than 5% and 10% respectively in order to recognise the profound effect that such a loss would have on a person’s life.

(d) The Digestive System (Page 49)

We submit that the overall gradients by generally 10% or in the case of Table 8.5 – The Liver, whereby the gradients are 15%, is too steep to assess a person’s impairment with respect to conditions effecting their gastrointestinal tract or diseases of the liver.

We submit that it would be appropriate for a gradient of 5% whole person in particular regarding conditions of the liver arising from hepatitis, the incidence of which is increasing, rather than the current increment of 0% then the next assessment at 15%.

(e) The Musculoskeletal System (Page 57)

By way of overview these Tables seek to, in effect, reintroduce the “Table of Maims” as outlined in s39(4) of the *CERC* 1971. That is, a specific injury or disease is required for the specific joint before it can be assessed. This is against the concept of a “whole person impairment” that was introduced by the SRCA in 1982.

(i) Knee injuries

An injury to the knee, irrespective of whether there is a loss in the range of motion due to a tear of the anterior cruciate ligament, medial meniscus or bucket handle tear, should attract a minimum 10% whole person impairment using Table 9.2 as the current Guide provides. We note in the “Attachment A” that the draft guide will not compensation such a condition at the minimum 10% whole person.

Similarly, members of the ADF who suffer from “bilateral compartment syndrome” whereby, under the current guide there is the potential for an assessment under Table 9.5 (notwithstanding that Attachment B denies that there would be such an assessment) can and often do receive an assessment at the minimum 10% whole person.

However there is no ambiguity that under the draft guide (Table 9.6) these conditions would not reach a 10% Whole Person Impairment.

(ii) Neurological Conditions – Lower Limbs

With respect to the assessment of secondary neurological conditions upon a person’s mobility, we note that the draft Guide provides a convoluted attempt to follow particular spinal nerve pathways from vertebral levels and their corresponding effects upon the lower limbs (ie Table 9.6.1 and 9.6.2.).

This assessment firstly requires specialised medical practitioners to undertake such an assessment which, under the Victorian WorkCover legislation has proved difficult. Secondly it again reduces the impact and concept of an injury upon a person’s “whole person” that such a secondary neurological condition, such as sciatica has on a person’s lower limbs and mobility that would otherwise attract 10% using Table 9.5 of the current Guide.

The “Attachment B” shows with respect to disc degeneration at the L3-S1 level together with large disc prolapse at L5-S1 level, lumbosacral disc prolapse, desiccation of the two lower lumbar discs or back pain and some S1 nerve root irritation would result in an impairment assessment of up to 30% whole person using Table 9.5 under the current Guide. Interestingly under the draft guide these conditions have only rated up to 10%.

The Draft Guide now requires an assessment to be undertaken it would seem in accordance with the AMA Guide. This will in turn require a complex medical examination and possible onerous costs upon the applicant for such an examination to be undertaken by their specialist.

The assessment for loss of shoulder should be simple whereby there is either loss of range of movement in the shoulder and/or the neurological effects upon the use of the limb with respect but not limited to, self care, grasping and fine motor skills.

The "Attachments A and B" disclose that a condition of subluxation of the right acromioclavicular joint may be assessed at 15% whole person impairment under the current guide when taking into account the neurological effects of such a condition upon a person's use of their upper limb. Under the draft Guide the assessment is only a 2% impairment. Assuming the condition did result in a loss of range of movement under the current guide it would attract a 27% impairment. Under the draft Guide a 26% whole person impairment is achieved only after a convoluted impairment assessment of the neurological damage is undertaken.

Assuming there was "only" a left shoulder subluxation, this will result in an impairment assessment of 10% under the current Guide. Under the draft Guide it is assessed at 0% impairment.

In some cases a shoulder injury with neurological consequences results in a modest increase using the draft Guide. However we reiterate that such an increase is extremely optimistic on the basis that medico legal practitioners are able to undertake such assessments to come up with the ideal and highest impairment assessment using the draft Guide.

In our experience, the doctors retained on behalf of the Commonwealth tend to be conservative in their assessment and therefore a lower impairment assessment can be reasonably assumed as opposed to the maximum one that Attachments A and B disclose.

(iv) Cervical Impairment (Page 93)

We are uncertain why the gradients within this Table are not consistent ie gradients commence at 0%, 8% and then increased by 10% to 18% thereafter.

If, the draft Guide attempts to clinically dissect trauma that may occur to the cervical spine, then it is reasonable that the trauma that is outlined within the criteria should attract a lower impairment ie gradients of 2% or a maximum of 5%. For example, if a person suffers a “non significant loss of motion segment integrity” this should, in our view be assessed at a minimum 5% impairment. This would ensure that those people who may have chronic soft tissue neck injuries could attract a 5% whole person impairment. This could then be combined with any secondary impairments, ie headaches to provide the minimum 10% whole person impairment to adequately compensate a person for such a chronic condition.

The fact that a person who has a “compression fracture” does not obtain a minimum 10% whole person impairment under the Draft Guide notwithstanding that they still have a loss of range of motion, is inequitable given the trauma that someone must experience if they have sustained a fracture to the vertebral body of the cervical spine.

Again the draft Guide attempts to provide clinical definitions and diagnosis of trauma to the cervical spine to such a degree that it will inevitably require extensive medico legal and radiological debate. This is inevitable to establish whether someone can be assessed at having a minimum 10% whole person impairment for sustaining an injury to their

neck that results in a combination of a loss of range of movement and/or a neurological impairment.

(h) The Reproductive System (Page 101)

We are uncertain why the draft Guide should limit traumatic injury to the groin sustained by males to a maximum of 20% whole person with an increase by 50% of that level if they are 39 years of age or younger.

If a male suffers trauma to the groin area that results in the loss of both testes (which would otherwise attract a maximum 20% whole person impairment under the Draft guide) together with or a subsequent erectile dysfunction or no sexual function possible ie a further 20%, no additional compensation is payable if they are over 39 years old.

The changing nature of relationships within Australia would indicate that people are deferring child rearing until possibly after age 39 and thereafter the loss of both testes *and* the denial of an additional lump sum for erectile dysfunction is inequitable.

It discriminates on the basis that a male who may have deferred having children until his 40's who then experiences traumatic injury to his groin at age 40 whereby he suffers the loss of both testes *and* is unable to have any sexual function is limited to 20% whole person impairment under the draft Guide.

Alternatively, why is the 20% whole person impairment the maximum benchmark when applying the formula of increasing the whole person impairment by 50% depending on the age of the person? It is submitted that for such traumatic loss that the Draft Guide should be at least 50% whole person impairment.

Under the draft Guide a current or former member of the ADF who may have sustained a "left hemisphere ischaemic infarct" prior to July 2004 and has yet to either make a claim or to be assessed for permanent impairment is substantially worse off under the Draft Guide ie 22% impairment for neurological conditions as opposed to a 37% impairment under the current guide.

This is a significant reduction of benefits payable to a person suffering from such traumatic brain injury and the subsequent effects upon their comprehension, speech, memory retention and emotional or other impairments whereby they will suffer a significant discount of the whole person impairment.

7. CONCLUSION

- 7.1 It is unfortunate that Comcare have firstly deemed that the Application of a second edition guide should take effect irrespective of the date of the injury or irrespective of why a person may not have made a claim for permanent impairment which is highly relevant to current and former members of the ADF.
- 7.2 Furthermore that Comcare have shown little interest to apparently consult either Department of Veterans' Affairs and the Ex-Service Organisations to determine whether the Draft Guide would have a significant impact on that section of the community who have undertaken inherently dangerous and unique service on behalf of their country.
- 7.3 The only remedy now available by Comcare is to firstly commence the extensive consultation with the Ex-Service Organisations and secondly ensure that if and when the second edition Guide is prepared that it does not apply retrospectively and result in a reduction of the whole person impairment that currently exists.

SIGNED:

31 March 2005

